Specialized Medical Supplies, Equipment, Assistive Technology and Appliances

Definition: Specialized medical equipment, supplies and assistive technology includes devices, controls, or appliances, specified in the plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, repairs not covered by warranty, replacement of parts or equipment and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. This service may include consultation and assessment to determine the specific needs related to the individual's disability for which specialized medical equipment, supplies and assistive technology will assist the individual to function more independently. Consultation and assessment cannot be used to determine the need for supplies.

Note: The purchase of assistive technology (microwaves, adapted telephones, etc.) must take the place for the need of either personal care or a direct care service.

Providers: Specialized medical supplies, equipment, assistive technology and appliances must be provided by vendors who are enrolled with SCDHHS as Durable Medical Equipment (DME) providers, by the local DSN Board to provide the service, or DDSN qualified providers. Vendors who are contracted through the local DSN board can **only** provide Medical Equipment, Supplies or Consultation. They cannot provide PERS. If a vendor is enrolled with SCDHHS as a DME provider, they **cannot opt to board bill**.

Note: Durable Medical Equipment (DME) is the name of a service available to all Medicaid individuals in South Carolina. It is not the name of a Community Supports Waiver service.

Arranging for the Service: Once the individual's need has been identified and documented in the plan, and it is determined that the provision of equipment or supplies will meet or address the need, you must determine if the needed equipment or supplies are available through the State Plan. The State Plan includes the service Durable Medical Equipment (DME) which is available to all Medicaid individuals and covers equipment or supplies ordered by a physician. **DME covers such equipment and supplies as hospital beds, wheelchairs, shower chairs, back and leg braces, crutches, oxygen, bandages, etc.** Furthermore, liquid nutrition (e.g. Ensure, Pedisure, Sustical, etc.) is covered by the State Plan as Durable Medical Equipment when the supplement is the individual's sole source of nutrition. If the individual has a "feeding tube" (e.g. G-Tube, J-tube, PEG tube, etc.) the supplements can be provided as Durable Medical Equipment and funded by the State Plan. The individual or his/her family must have a prescription for the product and show the enrolled DME Provider his/her Medicaid card to obtain. You must include the provision of the supplements in the individual's plan, but since this is funded by the State Plan, it does not need to be included on the Waiver Tracking System.

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To determine if an item is covered by the State Plan:

1. Ask the provider for the appropriate procedure code for the equipment or supply requested and compare it to the equipment and supply list included in the Medicaid Provider Manual for Durable Medical Equipment which is published by SCDHHS at www.scdhhs.gov. Click on "Provider Manuals" in the center of page and scroll down to "Durable Medical Equipment". Equipment and supply lists are under "Procedure Codes" in Section 4 of the manual. If a procedure code is not listed in the section, it is a "non-covered" item.

   Please Note: Items with ** require the providers to first submit a Prior Authorization to DHHS to determine whether an item is covered.

You must document your attempts to determine if the needed items are covered by the State Plan. For some equipment or supplies, SCDDHS places limits on the frequency or amount of an item an individual may receive. For example, up to 4 urinary leg bags can be provided during a calendar month. If the individual needs more than is allowed by the State Plan, the provider would initiate the appropriate **Certificate of Medical Necessity (CMN) Form** by filling out the top portion of page one and all of page two, then, forwards it to the individual's physician to complete the bottom portion to include medical justification and signature of approval. This form must be completed every 12 months. The provider sends the **original** CMN to you who then completes the **Authorization for Services Form** (**Community Supports Form AT-5**) and forwards copies of the authorization and CMN back to the provider.

In most instances, Specialized Medicaid Equipment, Supplies and Assistive Technology is provided by a vendor enrolled with SCDHHS as a DME provider. However, there may be circumstances when an individual's needs can be meet by a vendor that is not enrolled with SCDHHS as a DME provider Vendors who are **not** enrolled with SCDHHS as DME providers are allowed to contract with the local DSN Board to provide medical equipment, supplies and consultation ONLY. This option would be used for items such as non-sole source liquid nutrition and patient lift systems. This option should lead to reduced cost. This option is not available for items such as diapers, pull-ups, wipes, etc.

For any single piece of equipment or supply which costs **less than $1,500**, no bids are required. However, you must offer the individual/legal guardian the choice of provider. You must document this offering of choice.

For any single piece of equipment or supply which costs **more than $1,500**, you must offer the individual/legal guardian the choice of providers and assist with soliciting quotes from three (3) providers. These quotes may be verbal but must be documented in the record and included as a comment to the budget on the Waiver Tracking System (BDCOM). **NOTE:** For any single piece of equipment or supply costing more than $5,000, three (3) written quotes must be obtained and submitted to Cost Analysis Division of SCDDSN via fax at (803) 898-9657 when the request is added to the Waiver Tracking System.

Once the provider is chosen by the individual or selected as the "lowest bidder" from among those providers chosen by the individual/legal guardian and the budget information and comments have been entered in the Waiver Tracking System (S21) and approved, the service can be authorized. For providers enrolled with SCDHHS as DME providers, services are authorized by sending the **Authorization for Services (Community Supports Form AT-5)** to the chosen

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provider. In this instance, a copy of the **Authorization for Service (Community Supports Form AT-33)** must be sent to the DSN board's Director of Finance and the SURB Division SCDDSN Central Office. For providers that are contracted with the local DSN Board to provide Medical Supplies and Medical Equipment only, Medical Equipment and Medical Supplies services are authorized by sending the **Authorization for Services (Community Supports Form AT-33)** to the chosen provider.

1. **Medical Supplies** are those non-durable supplies that are not available through the State Plan and are of direct medical or remedial benefit to the individual. This may include items such as liquid nutrition (when **not** the sole source of nutrition) and wipes, but will not include items such as soap, deodorant, shampoo, tissues, toilet tissue, etc., unless clearly linked to a direct medical or remedial need in the plan.

   Please note: Wipes are available to those who are incontinent of bowel and/or bladder and are at least three (3) years old.

2. **Medical Equipment** is any durable or non-durable equipment item that is not covered by the State Plan and is of direct medical or remedial benefit to the individual. This includes items that are "assistive" in nature such as large button telephones, strobe light fire alarms, flashing light alarm clocks, or any other items that are clearly linked to a direct medical or remedial need in the plan.

3. **Personal Emergency Response System (PERS)** is an electronic device which enables the individual to secure help in the event of an emergency. The individual may wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center (that is staffed by trained professionals) once a "help" button is activated. PERS services are limited to those individuals who live alone, or who are alone for most of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. The rate for this service is set to $36.00 for installation and $36.00 per month for monitoring. Please use these amounts when entering budget requests onto the Waiver Tracking System.

   The **installation of a PERS** is a one-time authorization and should be accompanied by an authorization for monthly monitoring. PERS are not covered by the State Plan.

4. **Diapers** are not covered by the State Plan, but are available through the Community Supports Waiver to those who are incontinent of bowel and/or bladder and are at least three (3) years old. The cost of diapers are restricted by the pricing guidelines set by SCDHHS. These guidelines limit the provision of diapers to a maximum of three (3) cases per month per individual and requires that each case contain at least 72 size large diapers or 96 size medium or small diapers. The cost per case of small or medium size diapers will be $70.08. The cost for a case of large or extra large should be no more than $69.84.

If an individual needs a particular diaper that exceeds the cost per case rule, **medical necessity must be established.** When you identify the need for a specific diaper, he/she contacts a provider. The provider then initiates the appropriate **Certificate of Medical Necessity (CMN) Form** by filling out the top portion of page one and all of page two, then, forwards it to the individual's physician to complete the bottom portion to include medical justification and

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signature of approval. This form must be completed every 12 months. The provider sends the **original** CMN to you who then completes the **Authorization for Services Form** (**Community Supports Form AT-5**) and forwards copies of the authorization and CMN back to the provider. Given the exception to policy, diapers in this situation would be authorized under Medicaid Supplies (T2028) and not Diapers.

- If an individual needs more than the equivalent of 3 cases of diapers per month and the need for more diapers is **medically necessary**, then the **SCDHHS Department of DME Certificate of Medical Necessity Form** must be used. If the individual requests more than the maximum 3 cases allowed, a DDSN District Office approval is required. When you identify the need for more than 3 cases per month of diapers, he/she contacts a provider. The provider then initiates the appropriate **Certificate of Medical Necessity Form** by filling out the top portion of page one and all of page two, then, forwards it to the individual's physician to complete the bottom portion to include medical justification and signature of approval. This form must be completed every 12 months. The provider then sends you the **original** CMN to complete the **Authorization for Services** (**Community Supports Form AT-5**) **Form**. Forward that along with a **copy** of the CMN back to the provider. Given the exception to policy, diapers in this situation would be authorized under Medicaid Supplies (T2028) and not Diapers.

5. **Underpads** are not covered by the State Plan and the costs are also restricted by pricing guidelines set by SCDHHS. These guidelines limit the provision of underpads to a maximum of three (3) cases per month. A case of underpads is defined as at least 200 22"x33" underpads or at least 150 22"x35" underpads. Each case of underpads can cost no more than $43.65.

6. **Consultations** are not covered by the State Plan. Consultations can be used to assess and determine the specific needs related to the individual's disability for which specialized medical equipment, supplies and assistive technology will assist the individual to function more independently **prior to** the individual receiving the service. **Consultations and assessments cannot be used to determine the need for supplies only. Assistive Technology Assessments/Consultations must be provided by Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME).** A Consultation may be authorized by completing the **Authorization for Services (Community Supports Form AT-33).** The maximum amount allowed for a consultation is $300.00.

7. **Rental:** In certain circumstances, needs for equipment or supplies may be time limited (i.e. an individual is recovering from surgery and will need a bedside commode for 3 months). **"Time limited" rental should be used when a particular item will not be needed longer than 3 months.** In these circumstances, you should encourage the individual to rent the needed item from their choice of providers. You must initially verify that the rental costs **cannot be covered** by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of this rental can be funded through Specialized Medical Equipment, Supplies and Assistive Technology. This service would be authorized under Medical Equipment (T2029).

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8. **Repairs** not covered by warranty and replacement of parts may be funded through Specialized Equipment, Supplies and Assistive Technology. Repairs and/or replacement of equipment may not be granted if it is determined that there has been abuse or neglect of the equipment or **if the same repair has been done on the same piece of equipment more than twice in twelve (12) calendar months.** Consideration for further repairs must have documentation showing extenuating circumstances. You should use his/her best professional judgment when determining if abuse/neglect is occurring. This service would be authorized under Medical Equipment (T2029).

For each category of Assistive Technology items, the "Start Date" must be noted. The "Start Date" is the earliest date from which the provider can bill and receive payment for services. Along with the Start Date, the name of the item being authorized, the cost or dollar amount authorized and the frequency must be noted. The "frequency" indicates how often the provider can provide the item at the cost noted. For example, if the authorization shows "Item: 1 case Ensure Cost: $34.50 Frequency: Monthly", then the authorization allows the provider to provide 1 case of Ensure for $34.50 every month until a new authorization for Ensure is sent or until a **Notice of Termination of Service (Community Supports Form 16-B)** is sent to the provider. Another example would be if the authorization shows "Item: BellSouth Model TX200 Telephone Cost: $31.50 Frequency: one time", then the provider can provide one phone for $31.50.

Back dating of referrals is prohibited.

Please note: When sending a new service authorization to a provider, you nullify any previous authorization to that provider. This does not mean that an authorization for a one-time item provided two months ago is nullified. It means if you have an authorization for ongoing monthly supplies with that provider and you send a new referral you must include those monthly supplies that continue to be needed.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the individual's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following schedule should be followed when monitoring specialized medical supplies, equipment, assistive technology, and appliances:

- One time items: within two weeks of receipt of item
- Ongoing services: at least monthly for the first two months and then at least quarterly thereafter
- Start over with each new provider
- Any single item costing more than $1,500.00 requires an on-site monitorship within two weeks of receipt

One-Time Items

→ Did the individual receive the item?
→ What is the benefit of the item to the individual?
→ Is the item being used as prescribed?
→ Was the individual satisfied with the provider of the item?

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→ Was the provider responsive to the individual's needs?

On-going items

→ Has the individual's health status changed since your last monitorship? If so, do all authorized supplies continue to be needed at the current rate?
→ Are the amounts appropriate or do they need to be changed?
→ Are the specific brands appropriate to meet the individual's needs or does a change need to be made?
→ Are additional supplies needed at this time? Are there any new needs?
→ Does the individual receive his/her monthly supplies in a timely manner?
→ Is he/she satisfied with the provider of the service?
→ What are the supplies used for?
→ Are the items being used as prescribed?

Personal Emergency Response System (PERS)

→ At least monthly for the first two months
→ At least quarterly thereafter
→ Start over with each new provider

This monitoring will be considered complete when **one or more** of the following has been conducted:

- Review of documentation of services provided for the purpose of assessing the effectiveness, frequency, duration, benefits, and usefulness of the service (i.e. review of progress notes submitted by a psychologist providing psychological services)

- Conversation/discussion with the recipient, recipient's family/caregiver, or Day staff member for the purpose of determining the effectiveness, frequency, duration, benefits, and usefulness of the service.

- Conversation with the service provider about the effectiveness, frequency, duration, benefits, and usefulness of the service.

- On-site observation of the service being rendered for the purpose of determining the effectiveness, frequency, duration, benefits, and usefulness of the service.

Some items to consider during monitorship include:

→ Has the individual used the PERS since your last contact? If so, what was the response from the PERS provider?
→ Does the individual continue to be left alone at home for significant periods of time?
→ Is the individual satisfied with the PERS provider?
→ Is the provider receptive to the needs of the individual?
→ Does the service need to continue?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the individual or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal/reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or

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termination of the waiver service(s). See **Chapter 8** for specific details and procedures regarding written notification and the appeals process.

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S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORTS WAIVER
AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Individual's Name **Date of Birth**

_____
Address

Medicaid # / / / / / / / / / / /

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing Community Supports Waiver. Our information indicates this person has:
☐ Medicaid only ☐ 3rd Party liability (private insurance) ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # C S ____/____/____/____/____/

Specialized Medical Supplies, Equipment, Assistive Technology and Appliances:

_____ Medical Supplies (T2028) Start Date: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

_____ Medical Equipment (T2029) Start Date: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

_____ Personal Emergency Response System
Installation (S5160)
Monitoring (S5161) Start Date: _____

_____ Diapers _____ x _____ = _____
# of diapers in case # of cases total # of diapers needed
Small/Medium 96 diapers =1 case; Large 72 diapers = 1 case; X-Large 54 diapers = 1 case; maximum 3 cases
Frequency: ☐ Monthly ☐ Quarterly ☐ Bi-Monthly ☐ Bi-Annually
Size: ☐ Adult Small (T4521) ☐ Adult Medium (T4522) ☐ Adult Large (T4523)
☐ Adult X-Large (T4524) ☐ Child Small/Medium (T4529) ☐ Child Large (T4530)
☐ Youth (T4533) Start Date:_____

_____ Underpads (A4554) Start Date:_____
Amount: ☐ 1 case ☐ 2 cases ☐ 3 cases Frequency: _____

Service Coordinator/Early Interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____ _____
Signature of Person Authorizing Services Date

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S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORTS WAIVER
AUTHORIZATION FOR SERVICES
BILLED TO DSN BOARD

TO: _____

_____

RE: _____
Individual's Name / **Date of Birth**

_____
Address

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Specialized Medical Supplies, Equipment, Assistive Technology and Appliances**:**

_____ Medical Supplies Start Date: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

_____ Medical Equipment Start Date: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

_____ Consultation $_____ (not to exceed $300.00)

Service Coordinator/Early Interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____ _____
Signature of Person Authorizing Services Date

Copies to: SURB Division SCDDSN Central Office and DSN Board Director of Finance

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